

## DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

March 15, 2016

Ms. Beth Peer, Manager Our House Too Residential Care Home 69 1/2 Allen Street Rutland, VT 05701-4501

Dear Ms. Peer:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on **February 3, 2016.** Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN

PamelameotuRN

Licensing Chief

8027727733

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| Division                   | of Licensing and Pro   | otection,   |                         |   | ( 6) (10)                       | ALLIKOVED                |
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|                            | NT OF DEFICIENCIES<br>NOF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                         | PLE CONSTRUCTION<br>G:  | (X3) DATE                       | SURVEY<br>PLETED         |
|                            |  | 0377  | 8. WING _               |   |                                 | C<br>03/2016             |
| NAME OF                    | PROVIDER OR SUPPLIER   | STREET AL   | DRESS, CITY             | , STATE, ZIP CODE   |                                 |                          |
| OUR HO                     | USE TOO RESIDENT   | IAL CARE BUINGE   | LEN STREI<br>D, VT 0570 |   |                                 |                          |
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| R100                       | Initial Comments:  |   | R100                    |   |                                 | !                        |
|                            | conducted by the D<br>Protection in conjur<br>and an anonymous<br>of 2/2/16 -2/3/16. T<br>with both the survey | n-site re-licensure survey was<br>division of Licensing and<br>action with two entity reports<br>complaint between the dates<br>There were regulatory findings<br>y and the complaint<br>findings are as follows: |                         |   |                                 |                          |
| R136<br>SS≔A               | V. RESIDENT CAR  | E AND HOME SERVICES   | R136                    |   |                                 |                          |
|                            | 5.7. Assessment  | ·   |                         |   |                                 | į                        |
|                            | annually and at any change in the reside condition.  This REQUIREMEN by:                                       | t shall also be reassessed point in which there is a ent's physical or mental  IT is not met as evidenced view and confirmed by staff   | R136                    | Resident assessment ux<br>over due, since survey<br>Findings, the annual<br>assessment has bee<br>completed - all asses<br>are to be Kept Currer<br>RN 13 aware of expe | as<br>ors<br>(<br>un<br>sments  |                          |
|                            | interview the facility<br>sampled residents (<br>any point in which the  | failed to reassess 1 of 10<br>Resident #2), annually or at<br>nere is a change in the<br>or mental condition. The   |                         | are to be kept Currer  RN 13 aware of exper  and will be more dilit  House mar will monit  assessment due dutes I  be reviewed at the fire                              | nt-<br>todians<br>gent.<br>tor. | 2/4/16                   |
|                            | admitted to Our Hoo<br>assessment form id  | n 2/2/16, Resident #2 was<br>use Too, on 1/8/15. State<br>lentifies that the assessment<br>signed by the Registered<br>/15.   |                         | assessment due dates the fire the fire the fire the monthly many of each monthly many   | will<br>st<br>th<br>agers       |                          |
|                            | an annual review a<br>Therefore, the annu  | ne RN on 2/2/16 at PM, the resident has not had ssessment as of today. It is also assessment is 13 days   | <br>                    | tresday of each more at the monthly mane meeting, west will be advised of any shorted to be corrected immedia   | mings<br>tely                   |                          |
| IVISION OF LI<br>ABOBATORY | censing and Protection OREOTOR'S OR PROVID   | ER/SUPPLIER REPRESENTATIVE'S SIG  | N                       | TITLE 3/9   | 16                              | (XB) DATE                |
| JAME FOR                   | 2 / L  | ^"  | 1 anage                 | P9JV11  | If continuati                   | on sneet 1 of 26         |

Administrator R136-R999 POC'S accepted 3/15/16 BBOHEIRN/PME

| of Licensing and Pro  | otection   |   |  | FORIV  | APPROVED   |
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| PROVID <b>ER</b> OR SUPPLIER  | STREET A   | DDRESS, CITY,   | STATE, ZIP CODE  | 1 2 2  |  |
| USE TOO RESIDENTI   | AL CARE DUVIE  |   |  |  |  |
| (EACH DEFICIENCY  | 'MUST BE PRECEDED BY FULL  | ID<br>PREFIX<br>TAG   | (EACH CORRECTIVE ACTION SHOUL  | D BE   | (X5)<br>COMPLETE<br>DATE   |
| Continued From pa   | ge 1   | R136  |  |  |  |
| over due,   |  | }   |  |  | i  |
| V. RESIDENT CAR   | E AND HOME SERVICES  | R142  |  |  | i  |
| 5.8 Level of Care a   | nd Nursing Services  |   |  |  |  |
| 5.9.b The following a residential care ho granted by the licentherapy; ventilators dirrigation; feeding tu decubitus; suctionin This REQUIREMEN by: Based on staff intenfacility failed to obtain   | services are not permitted in ome except under a variance sing agency: intravenous or respirators; daily catheter bes; care of stage III or IV g; sterile dressings.  T is not met as evidenced view and record review, the n a variance for 1 of 6  | R142  | New LOC Variance reg   | vast<br>tor  | 3/21/16  |
| residents reviewed in<br>Resident # 7. Findir   | n the survey sample,<br>nas include:   |   | Variances will be review   | Mangga   | <b></b>  |
| During observation of Resident #7 was recifeeding tube, placed medical record did novariance has been of Manager was sure the placed to the State Areported there was not had been given. On AM, the senior mana owner/administrator and s/he did not knowariance and the owner available until new with the house mana | on day one of the survey, eiving feedings through a in the abdomen. The ot provide evidence that a btained, but the House here was one. A call was gent at 4:20 PM and they o evidence that a variance 2/3/16 at approximately 9:30 ager stated that the would have that information with the whereabouts of the her/administrator would not at week. Further interview ger at 4:30 PM, s/he was   |   | and requested immedia  | dely   |  |
|   | PROVIDER OR SUPPLIER USE TOO RESIDENT!  SUMMARY STA (EACH DEFICIENCY REGULATORY DR L.  Continued From pa over due.  V. RESIDENT CAR  5.9.b The following a residential care ho granted by the licenstherapy; ventilators of irrigation; feeding turdecubitus; suctionin  This REQUIREMEN by: Based on staff intervice facility failed to obtain residents reviewed in Resident #7. Finding the state of the | PROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFORMATION)  Continued From page 1  OVER DUE TO CARE AND HOME SERVICES  5.8 Level of Care and Nursing Services  5.9.b The following services are not permitted in a residential care home except under a variance granted by the licensing agency: intravenous therapy; ventilators or respirators; daily catheter irrigation; feeding tubes; care of stage III or IV decubitus; suctioning; sterile dressings.  This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the facility failed to obtain a variance for 1 of 6 residents reviewed in the survey sample, Resident #7. Findings include:  During observation on day one of the survey, Resident #7 was receiving feedings through a feeding tube, placed in the abdomen. The medical record did not provide evidence that a variance has been obtained, but the House Manager was sure there was one. A call was placed to the State Agent at 4:20 PM and they reported there was no evidence that a variance had been given. On 2/3/16 at approximately 9:30 AM, the senior manager stated that the owner/administrator would have that information and s/he did not know the whereabouts of the variance and the owner/administrator would have that information and s/he did not know the whereabouts of the variance and the owner/administrator would not be available until next week. Further interview with the house manager at 4:30 PM, s/he was unable to locate a variance for care for Resident | A BUILDING  OF CORRECTION  (X1) PROVIDER CURRECTION  (X2) MULTIF A BUILDING  DOT CORRECTION  (X2) MULTIF A BUILDING  B WING  STREET ADDRESS, CITY, 69 1/2 ALLEN STREET RUTLAND, VT 05701  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY DR LSC IDENTIFYING INFORMATION)  Continued From page 1  over due.  V. RESIDENT CARE AND HOME SERVICES  5.9.b The following services are not permitted in a residential care home except under a variance granted by the licensing agency: intravenous therapy; ventilators or respirators; daily catheter irrigation; feeding tubes; care of stage III or IV decubitus; suctioning; sterile dressings.  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STATE, ZIP CODE STATE, ZIP COD | NOT DEPENDENCIES OF CORRECTION  STREET ADDRESS, CITY, STATE, ZIP CODE SOLUTION  SUMMARY STATEMENT OF DESCREACES (EACH DEFICIENCY MAN BE PRECEDED BY FULL REGULATORY DRUG IDENTIFYING INFORMATION)  PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE SOLUTION, VT 05701  SUMMARY STATEMENT OF DESCREACES (EACH DEFICIENCY MAN BE PRECEDED BY FULL REGULATORY DRUG IDENTIFYING INFORMATION)  PREFIX REGULATORY DRUG IDENTIFYING INFORMATION)  PREFIX CAND EXCEPTION AND CORRECTION  CONTINUED FROM DEGREE TO THE APPROPRIATE  DEFICIENCY  PRESIDENT CARE AND HOME SERVICES S.8 Level of Care and Nursing Services  S.9.b. The following services are not permitted in a residential care home except under a variance granted by the licensing agency, intravenous therapy, ventilators or respirators, daily catheter irrigation, fedding tubes, care of stage III or IV decubitive; suctioning; sterile dressings.  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A call was placed to the State Agent at 420 PM and they reported there was no evidence that a variance has been obtained have that information and s/he did not know the whereabouts of the variance and the owner/administrator would not be available to locate a variance for care for Resident |

Division of Licensing and Protection

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| AND PLAN                 | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |  | (X2) MULTIPLE CONSTRUCTION |   | (X3) DATE SURVEY<br>COMPLETED              |                          |
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| ·····                    |  | 0377   | B. WING                    |   |  | C<br>03/2016             |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AC  | DRESS, CITY                | STATE, ZIP CODE   |  |                          |
| OUR HC                   | OUSE TOO RESIDENTI.  | AL CARE HOME   | LEN STREE                  |   |  |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | FEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SCIDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG        | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY)   | BE   | (X5)<br>COMPLETE<br>DATE |
| R155                     | Continued From pag   | je 2   | R155                       |   | 77   | <u></u>                  |
| R155<br>SS≃E             | V. RESIDENT CAR  | EAND HOME SERVICES   | R155                       |   |  |                          |
|                          | administration of or a medication in accord policies.  This REQUIREMEN' by: Based on observation review, the nurse fails administering of medicacordance with the residents observed, I Findings include:  1.) Per observation, administered enterion milligrams by mouth medication delegated. Ferrous Sulfate and padministered it to Reconfirmed immediate that the Ferrous Sulfated that the Ferrous Sulfated that the padministered Nurse (RI discovery, that the padministered Nurse (RI discovery), that the padministered because it where the padmin | home's policies for 5 of 9 Residents #4, 7, 8, 9 & 11.  Resident #4 was coated Ferrous Sulfate 325 on 2/2/16 at 5:25 PM. The distaff member crushed the claced it in applesauce and sident #4. The staff member distributed in | R155                       | All of these bullets have been reviewed with the RN and the manager to assure an appropriate Plan to Correct—  • Checking orders from the pharmacy—  • Communicating with I to assure viculistic ord.  • Testing, observing and educating med Certific Staff Frequently will force staffs awarenes of expectations—  RN and manager will monitor for accuracy and Compliance—  New weekly skills  Competency check is being developed for RN and Manager—  RN will monitor result | de<br>Joctoes<br>ers<br>d<br>ed<br>u<br>ss | 3/2/16                   |
|                          | (milligrams) and the la<br>(milliliter) and to give  | 30 ml. The medication  |                            | with Manager -  |  |                          |

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| ····                     |   | 0377  | B. WING                  |  | C<br>02/03    | 3/2016                   |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY.             | STATE, ZIP CODE  |               |                          |
| OUR HO                   | USE TOO RESIDENTI   | AL CARE HOME 69 1/2 ALI   | LEN STREE<br>), VT 05701 | <del>:</del> τ   |               | į                        |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRICIENCY)   | DBE .         | (XS)<br>COMPLETE<br>DATE |
| R155                     | delegated staff men administered only 1 administration the la with the staff membonly 10 ml instead of and s/he then preparemaining dose of 2 at this time and s/he needs to read the la 3.) Per observation administered Acetar at 12:15 PM, the member applied two into his/her gloved his/her siden staff member was a expired and s/he stabecause there is no expiration. The ordestate that the dose in member was asked squirts was equivaled that s/he does not keep that two squirts, but it taught to apply. The that two squirts are of the RN also confirm no expiration date of staff should be picking a telephone order Administration Reconot have signatures administering the way of the survey, one or | nber prepared and 0 ml via feeding tube. After abel and order was reviewed er and s/he confirmed that of the ordered 30 ml was given ared and administered the 0 ml. Reviewed with the RN estated that the staff member bel closer.  In, Resident # 9 was minophen topically on 2/2/16 edication delegated staff of squirts from the pump bottle ands and applied it to the sked when the medication atted that they did not know thing on the label to indicate er and the label on the bottle is 325 mg/2 ml. The staff how they knew that two ent to 2 ml and s/he stated how if that is how much is in that was the way they were equivalent to 2 ml at 4:30 PM. The staff how they knew that there is not the label and stated that the ing up on that.  In an order to administer 100 hour, dated 1/31/16, obtained and (MAR) for February does | R155                     | New medications received be added to MAR by Right manager will review for accuracy.  Weekly training/testing will be conducted for random staff Competence results will be reviewed with manager and RN Necessary actions we be taken immediately RN and manager with monitor skills and training. | 0 - 3 - 4 - U | 2/4/16                   |
|                          | hours of 10 AM and  |   |                          |  |               |                          |

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| NAME OF                  | PROVIDER OR SUPPLIER   | STREET AL  | DRESS OFF                | BTATE, ZIP CODE  | 02/03/                 | 2010                     |
|                          | OUSE TOO RESIDENT!   | AL CARE HOME 69 1/2 AL   | LEN STREE<br>D, VT 05701 |  |                        |                          |
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| R155                     | Continued From pa  | ge 4   | R155                     |  |                        |                          |
|                          | administration of waduring medication at feeding tube after Jumember that was rethe flushes on the distribution to indicate the flushes that they were order resident had a temp of the feeding the per trainaspirate for residual feeding. Confirmation at 11:47 AM that place checked. Again on the decing was observed placement and did in administration of feeding was observed placement and did in administration of feeding the this time.  6.) On 2/2/16 at 2:00 delegated staff memore and did in the placed the medicate when it was offered, then placed the medicate designated box. At the coming staff responsion administration was at Resident #11 had rethat it was in the medicate staff member placed Nurse to let him/her ligiven at 2:00 and askitime. When s/he reconstruction was here to the signal of the reconstruction of the medicate was in the | difference of the resident was definistration and to flush the evity feeding. The staff esponsible for administering ay shift had signed the MAR es were done. The RN stated ed every hour because the erature.  The resident of the ning and policy. She did not prior to administration of the ning and policy. She did not prior to administration of the ning and policy. She did not prior to administration of the nade by the staff member cement had not been 2/2/16 at 4:25 PM, the er responsible for the tube ed not to check tube for ot check residual prior to ding. Confirmation made by the medication ber prepared Risperidone Resident #11. The resident not accept the medication. The medication delegate icine cup with the medication e closet in the residents are change of shift the on lible for medication. |                          |  |                        |                          |

| Division                 | <u>of Licensing and Pro</u>   | otection   |                          |  |                   |                          |
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|                          |   |  |                          |  | , 02,0            | <u></u>                  |
| NAME OF I                | PROVIDER OR SUPPLIER  |  | -                        | STATE, ZIP CODE  |                   |                          |
| OUR HO                   | USE TOO RESIDENTI   | AL CARE HOME   | LEN STREE<br>), VT 05701 |  |                   |                          |
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| R155                     | Continued From pa   | ge 5   | R155                     |  |                   |                          |
|                          | closet and then crus<br>Resident #11. At 3:<br>s/he had given the o<br>other caregiver. Pe<br>PM, s/he stated tha<br>anything that was p<br>s/he was not made   | e day shift caregiver from the shed it and administered it to 20 PM s/he confirmed that medication prepared by the interview with the RN at 4:30 the staff are not to give repared by anyone else and aware at the time of the call had been prepared by the day   |                          | ·  |                   |                          |
|                          | delegated staff mer mg by mouth to Res medical record pres orders, dated 1/5/16 have Lasix 40 mg o (morning) as neede MAR reviewed with PM and s/he confirm chart and the MAR order is to give as give every day. S/h the RN check the oresident has been relong time, but confir given only as neede | 200 AM, the medication on the mber administered Lasix 40 sident #8. Review of the sents that the physician a states that resident is to one tablet oral daily in AM of for swelling. Orders and the house manager at 3:10 med that the orders in the do not match and that the needed and the MAR is to be said that they would have reders. The RN stated that the eceiving Lasix every day for a med that the orders are to be ed. S/he stated that they are cking the MAR and physician |                          |  |                   |                          |
| R161<br>SS=E             | V. RESIDENT CAR   | E AND HOME SERVICES  | R161                     |  |                   |                          |
|                          | 5.10 Medication   | Management   |                          |  |                   |                          |
|                          | for ensuring that all according to the hor  | er of the home is responsible medications are handled me's policies and that a fully trained in the policies   |                          |  | ·<br>-            | :<br>:                   |

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Division of Licensing and Protection (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ CB, WING 0377 02/03/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 69 1/2 ALLEN STREET OUR HOUSE TOO RESIDENTIAL CARE HOME RUTLAND, VT 05701 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R161 Continued From page 6 R161 and procedures, This REQUIREMENT is not met as evidenced weekly skills check will identify staff who are not following instructions/procedures-outcome of each will RIGI Based on observation, staff interview and record review, the manager of the facility failed to ensure that all medications are handled according to the home's policies for 2 of 9 residents, Resident #7 and 11. Findings include: 1.) Resident #7 has an order to administer 100 determine what training is to follow or that they are suspended from med passes at least m! of water every hour, dated 1/31/16 and 4/1/14 obtained via a telephone order. Review of the Medical Administration Record (MAR) for February does not have signatures for the night shift administering the water flushes. During day one of the survey, one or more surveyors were near the entrance to Resident #7's room between temporarily. the hours of 10 AM and 4:30 PM. The only administration of water for the resident was manager and RN will monitor for completion during medication administration and to flush the feeding tube after Jevity feeding. and create action plan on a case by Case basis. During the observed tube feedings for Resident #7 on 2/2/16 at 11:00 AM, the staff member did not check for placement of the feeding tube per training and policy. S/he did not aspirate for residual. Confirmation made by the staff member at 11:47 AM. On 2/2/16 at 4:25 PM, the staff member responsible for the tube feeding was observed not to check tube for placement and did not check residual. Confirmation made by staff at this time. Interview with the house manager at 4:30 PM after s/he was notified of the finding, stated that the staff knows they are suppose to check the placement of the feeding tube before they administer anything via the tube. S/he further stated that they have all been taught.

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| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE | (X5)<br>COMPLETE<br>DATE |
| Ř161                     | Continued From page   | ge 7  | R161                |  |       |                          |
|                          | delegated staff men 0.125 milligrams for was not alert and diwhen it was offered, then placed the medicin shift the on coming a medication administ Resident #11 had re it was in the medicin member placed a calet him/her know tha 2:00 and asked if it of When s/he received medicine, s/he retrie prepared by the day closet and then crus Resident #11. Policy medications are not but the person that p s/he confirmed that a medication prepared | ration was alerted that fused the medication and that is closet. At 3:10 PM the staff all to the Registered Nurse to it it had not been given at could be given at this time, the approval to give the eved the Risperidone that was shift caregiver from the hed it and administered it to be administered by anyone prepares them. At 3:20 PM is/he had given the by the other caregiver. Per it at 4:30 PM, s/he stated that ive anything that was |                     |  |       |                          |
| R163<br>\$S=D            | V. RESIDENT CARE  | EAND HOME SERVICES  | R163                |  |       |                          |
|                          | 5.5 Medication Mana   | agement   |                     |  |       |                          |
| i                        |   | equires medication<br>ensed staff may administer<br>re following conditions:  |                     |  | 1     |                          |
|                          | (1) A registered nurs<br>assessment consiste  | e must conduct an<br>int with the physician's   |                     |  |       |                          |

| Division                 | of Licensing and Pro   | otection  |                          | . <u> </u>  | , Order            | ALL HOVED                |
|--------------------------|--|---|--------------------------|---|--------------------|--------------------------|
|                          | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | 1                        | E CONSTRUCTION  | (X3) DATE<br>COMPI |                          |
|                          |  | 0377  | B. WING                  |   | 02/0               | :<br>3/2016              |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREETAD  | DRESS, CITY,             | STATE, ZIP CODE   |                    |                          |
| OUR HO                   | USE TOO RESIDENTI  | IAL CARE HOME   | LEN STREE<br>), VT 05701 | Т   |                    |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)  | D BE               | (XS)<br>COMPLETE<br>DATE |
| R163                     | as required in section.  This REQUIREMENT by: Based on staff interfacility failed to ens   | rs of the resident's care needs on 5.7.c  NT is not met as evidenced view and record review, the ure that the registered nurse  | R163                     | All Systems check has been reviewed with Rr. Manager and Caregive.  | ۔ ۍر               | 2/16/14                  |
|                          | physician's orders of Resident #5 and 8.  1.) On 2/2/16 at 5: administration, the dose of Warfarin shecause there were the Medication Adm to give Warfarin 2.5 PM and the one list give Warfarin 2 mg medical record stat daily. At 4:55 PM that she checks the month before dimedical record. She orders so know must have missed thouse manager will 2.) On 2/3/16 at 8: | sment consistent with the for 2 of 9 residents reviewed, Findings include:  25 PM, during medication delegated staff asked which hould Resident # 8 be getting a two of them. One order on hinistration Record (MAR) read is milligrams (mg) daily at 5:00 ed inght above that said to . The physician order in the ed to give the Warfarin 2 mg he Registered Nurse (RN) as the medication training and AR each month. S/he stated a MAR against the one from besn't check them against the he said that s/he reviews all is if there is anything new and this one, but confirms that the sometimes take orders.  00 AM, the medication mber administered Lasix 40 |                          | All Changes have been made for accuracy— RN monthly Audit procedure change will assist in identifying a RN daily review of Changes as needed ax House manager will monitor. | U<br>U<br>U        |                          |
|                          | mg by mouth to Re medical record presorders, dated 1/5/16 have Lesix 40 mg c (morning) as needs MAR reviewed with PM and s/he confined   | mber administered Lasix 40 sident #8. Review of the sents that the physician 5 states that resident is to one tablet oral daily in AM and for swelling. Orders and the house manager at 3:10 med that the orders in the do not match and that the   |                          |   |                    |                          |

| Division                 | of Licensing and Pro  | otection  |                          |   | FORM        | MAPPROVED                |
|--------------------------|---|---|--------------------------|---|-------------|--------------------------|
| STATEME                  | NT OF DEFICIENCIES<br>N OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;  |                          | PLE CONSTRUCTION<br>5:  |             | E SURVEY                 |
| <u>.</u>                 |   | 0377  | B. WING                  |   | 00          | C                        |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AD   | DRESS CITY               | STATE, ZIP CODE   | 1 02,       | /03/2016                 |
| OUR HO                   | USE TOO RESIDENTI   | AL CARE HOME 69 1/2 AL  | LEN STREE<br>D, VT 05701 | :T  |             |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF COF<br>(EACH CORRECTIVE ACTION<br>CROSS-REFERENCED TO THE<br>DEFICIENCY) | I SHOULD BE | (XS)<br>COMPLETE<br>DATE |
| R163                     | Continued From page   | ge 9  | R163                     |   |             | <del></del>              |
|                          | order is to give as nevery day. S/he said check the orders. Of the RN stated that the RN stated that the receiving Lasix event confirmed that the oneeded. S/he stated checking the MAR at 3.) During medical #8 has an order for Caily as needed for gMAR and medication signed physician order for Colchicine. manager at 3:10 PM the doctor and a list with him/her. S/he simedications after a gRN confirmed that shand did not realize the recent signed orders.  4.) On 2/3/16 medic presents that s/he was 11/7/15 with diagnosi Artery Disease, Arter Vascular Disease and His/her physician ordinave Toprol XL 100 m 50 mg by mouth daily not represent that the Toprol XL. Reviewed 3:10 PM and s/he coorders included that the orders. Per interview | eeded and the MAR is to give of that they would have the RN puring interview at 4:10 PM, he resident has been y day for a long time, but reders are to be given only as a that s/he is responsible for and physician orders.  Teview on 2/3/26, Resident Colchicine 0.6 mg by mouth yout flare-ups, listed on the a list. Review of the last ers dated 1/15/16, there is no Per interview with the house, the resident was taken to of the medications was taken and that the RN reviews the loctor visit. At 4:10 PM, the he reviews the medications e medication was not on the resident was taken and that the RN reviews the loctor visit. At 4:10 PM, the he reviews the medications e medication was not on the resident coronary in Pacemaker placement, ers represent that s/he is to not tablet (1/2 tablet) to equal the Review of the MAR does resident is to take the with the house manager at a firmed that the admission he Toprol XL was part of the with the RN at 4:10 PM, and spoke with the Physician is not review the | R163                     |   |             |                          |
| ! r                      | nedications and was<br>needed to be on the T  | oprol because of his  |                          |   | · .         |                          |

| Division                 | of Licensing and Pro  | otection  |  |  | · · · · · · · · · · · · · · · · · · · |
|--------------------------|---|---|--|--|---------------------------------------|
| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  |  | LE CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED         |
|                          |   |   | A. DOIGDING  |  |                                       |
|                          |   | 0377  | B. WING  |  | 02/03/2016                            |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD   | DRESS, CITY,   | STATE, ZIP CODE  |                                       |
| OHE NO                   | USE TOO RESIDENTI   | AL CARE HOME 69 1/2 AL  | LEN STREE  | <b>T</b>   |                                       |
| OUK NO                   | OSE TOO RESIDENT  | RUTLANI   | O, VT 05701  |  |                                       |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG  | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)   | LD BE COMPLETE                        |
| R163                     | Continued From pa   | ge 10   | R163   |  |                                       |
|                          | not question the To<br>from November to I<br>s/he reviews and pr<br>month, but s/he will  | S/he confirmed that s/he did prol not being carried over December. S/he stated that repares the MARs each often take them home and didnes not review the orders cord. | - The state of the |  |                                       |
| R165<br>\$\$=F           | V. RESIDENT CAR   | E AND HOME SERVICES   | R165   |  |                                       |
|                          | 5.10 Medication Ma  | anagement   | R.165  |  | no a l                                |
|                          | administration, unlie   | requires medication<br>censed staff may administer<br>the following conditions:   |  | Weekly sluils/training for .<br>Certified staff will be  | med 3/17/16<br>cted                   |
|                          | medications, and is i. Teaching desig for medication adm appropriate inf  | e proper administration of  |  | Weekly sluils/training for certified staff will be implemented and Cordu by an RN - outcome will be discussed a weekly managers men manager will monitor | t<br>etns                             |
|                          | side effects; ii. Establishing a communication with resident's condition as well as changes iii. Assessing the need for any chang Monitoring and eva performance in carrinstructions. | process for routine<br>designated staff about the<br>and the effect of medications,   |  |  |                                       |
|                          | Based on staff inter<br>facility failed to ensi   | view and record review, the<br>ure that the Registered Nurse<br>for teaching, monitoring and  | !<br>!<br>!<br>!<br>!  |  | •                                     |

| Division                 | of Licensing and Pro   | otection   |                     |  |                               |
|--------------------------|--|--|---------------------|--|-------------------------------|
| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|                          |  | 0377   | B. WING             |  | C<br>02/03/2016               |
| NAME DE I                | PROVIDER OR SUPPLIER   | STREET AD  | ORESS CITY I        | STATE, ZIP CODE  |                               |
|                          |  | 69 1/2 AL  | LEN STREE           |  |                               |
| OUR HO                   | USE TOO RESIDENT   | IAL CARE HOME  | ), VT 05701         |  |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE COMPLETE                |
| R165                     | Continued From pa  | ge 11  | R165                |  |                               |
|                          | carrying out the nur   | ted staff performance in se's instructions fro stration. Findings include:   |                     |  |                               |
| :                        | 10:00 AM, s/he stat<br>caregivers that will  | ouse manager on 2/3/16 at<br>ted that s/he trains the<br>be delegated to pass<br>said that s/he first gives them a             |                     |  |                               |
|                          | test to take, she ha policy/procedure to   |  |                     |  |                               |
|                          | shadowing another member. S/he furt  | ss while the caregiver<br>delegated medication staff<br>ther stated that the RN does<br>training until it is time for them     |                     |  |                               |
|                          | to be certified. Who<br>member is compete<br>the staff member to<br>time for the RN to c | en the manager feels the staff<br>ent, s/he sets up the time for<br>shadow and then sets up a<br>come in to watch a medication |                     | ·  |                               |
|                          | pass and then the f  | RN will deem them as certified.  |                     |  |                               |
|                          |  | that the RN doesn't<br>itor the day shift because s/he<br>juestions and the RN   |                     |  |                               |
| ,                        | evaluates and mon house manager als  | tors the evening shift. The o stated at this time that s/he r staff that will be doing tube                                    |                     |  |                               |
|                          | feedings. S/he said<br>Medication Adminis  | I that she will show them the tration Record, where the  |                     |  |                               |
|                          | check for residual b   | ity is kept, how to clean and<br>by aspirating before giving   |                     |  |                               |
|                          | medications or the for competency dur  | Jevity. The RN will then checking medication certification.  |                     |  |                               |
|                          | medication training  | interview, s/he says that the consists of giving the   | :<br>!              | •  | ;<br>•                        |
|                          | handbook to study<br>through the book w  | the house manager goes<br>ith them. S/he said that she   |                     |  |                               |
|                          | will correct the test  | after they take it and then they<br>manager or whoever s/he  |                     |  |                               |

| of Licensing and Pro  | tection  |  | <u>, , , , , , , , , , , , , , , , , , , </u>  | <del>,,</del>                            |  |
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| IT OF DEFICIENCIES  | (X1) PRDVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | ' '  |  | (X3) DATE S<br>COMPLI                    |  |
|   |  | A. BUICOING.   |  | C  |  |
| •   | 0377   | B. WING  |  | 1  | /2016  |
| PROVIDER OR SUPPLIER  | STREETAD   | DRESS, CITY, 5   | STATE, ZIP CODÉ  |  | :  |
| USE TOO RESIDENTI   | 'AL CARE HOME  |  | <b>r</b>   |  |  |
|   | RUILANI  | ), VT 05701  |  |  |  |
| (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL   | ID<br>PREFIX<br>TAG  | (EACH CORRECTIVE ACTION SHOUL  | DBE :                                    | (X5)<br>COMPLETE<br>DATE   |
| Continued From pa   | ge 12  | R165   |  |  |  |
| pass with them. S/<br>are done by other to  | he said that the tube feedings han him/her and before they   |  |  |  |  |
| V. RESIDENT CAR   | E AND HOME SERVICES  | R166   |  | ,  | }  |
| 5.10 Medication Ma  | anagement  | R166   | Communication: The Correction of the Correction  | gwer -                                   | 2/3/14   |
| <ul> <li>5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:</li> <li>(4) All medications must be administered by the person who prepared the doses unless the nurse responsible for delegation approves of an alternative method of preparation and administration of the medications.</li> </ul> |  |  | benefit all staff in or  | der                                      |  |
|   |  |  | of decision making RN and House mana   | ger                                      |  |
| by:   |  |  | will monitor.  |  |  |
| facility failed to insu<br>administered by the<br>doses unless the ne<br>approves of an alte  | re that all medications e person who prepared the urse responsible for delegation rnative method of preparation  |  |  |  |  |
| staff member prepared in milligrams for Residence and did not it was offered. The placed the medicine control the on coming staff   | ared Risperidone 0.125 dent #11. The resident was at accept the medication when medication delegate then e cup with the medication in it loset. At the change of shift responsible for medication  |  |  | :  |  |
|   | PROVIDER OR SUPPLIER USE TOO RESIDENTI SUMMARY STA (EACH DEFICIENCY OR L Continued From pa delegates and then pass with them. S/ are done by other ti do it alone, s/he wil off to certify.  V. RESIDENT CAR  5.10 Medication M  5.10.d If a resident administration, unli- medications under  (4) All medications person who prepare responsible for dele alternative method administration of th  This REQUIREMED by: Based on observati facility failed to insta administered by the doses unless the n approves of an alte and administration  On 2/2/16 at 2:00 F staff member prepare milligrams for Resident it was offered. The placed the medicine of the on coming staff | OF CORRECTION  O377  PROVIDER OR SUPPLIER  USE TOO RESIDENTIAL CARE HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 12  delegates and then the RN will do a medication pass with them. S/he said that the tube feedings are done by other than him/her and before they do it alone, s/he will be with them and then sign off to certify.  V. RESIDENT CARE AND HOME SERVICES  5.10 Medication Management  5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:  (4) All medications must be administered by the person who prepared the doses unless the nurse responsible for delegation approves of an alternative method of preparation and administration of the medications.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure that all medications administered by the person who prepared the | TO DEFICIENCIES OF CORRECTION  (X1) PROVIDER/SUPPLIER OT THE PROVIDER/SUPPLIER/CLA DEPTIFICATION NUMBER:  (X2) MULTIPL A. BUILDING:  (X3) MUSE TOO RESIDENTIAL CARE HOME  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPTICENCY MUST BE PRECEDED BY PULL PREFIX TAGE  Continued From page 12  delegates and then the RN will do a medication pass with them. S/he said that the tube feedings are done by other than him/her and before they do it alone, s/he will be with them and then sign off to certify.  V. RESIDENT CARE AND HOME SERVICES  5.10 Medication Management  5.10.d If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:  (4) All medications must be administered by the person who prepared the doses unless the nurse responsible for delegation and administration of the medications.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure that all medications administration of the medications.  On 2/2/16 at 2:00 PM the medication delegated staff member prepared Risperidone 0.125 milligrams for Resident #11. The resident was not alert and did not accept the medication when it was offered. The medication delegate then placed the medicine cup with the medication in it into the medicine cup with the medication in it into the medicine cup with the medication in it into the medicine cup with the medication in it into the medicine cup with the medication when it was offered. The medication delegate then placed the medicine cup with the medication in it into the medicine cup with the medication when it was offered. The medication for medication when it was offered. The medication delegate then placed the medicine cup with the medication in it into the medicine closet. At the change of shift the on coming staff responsible for medication. | TO DE DEFICIENCIES OF CORRECTION    NOTE | OF CORRECTION  (N1) PROVIDER SUPPLIER (LIAND, NUMBER:  0377  STREET ADORRESS, CITY, STATE, ZIP CODE  69 1/2 ALLEN STREET RUTLAND, VT 03701  SUMMARY STATEMENT OF DEPICIENCES  (RECHLATORY OR LSD IDENTIFYING INFORMATION)  (RECHLATORY OR LSD IDENTIFYING INFORMATION)  COntinued From page 12  delegates and then the RN will do a medication page with them. She said that the tube feedings are done by other than him/her and before they do it alone, she will be with them and then sign off to certify.  V. RESIDENT CARE AND HOME SERVICES  5.10 Medication Management  5.10.4 If a resident requires medication administration, unlicensed staff may administer medications under the following conditions:  (4) All medications must be administered by the person who prepared the doses unless the nurse responsible for delegation approves of an alternative method of preparation and administration of the medications.  This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to insure that all medications administered by the person who prepared the doses unless the nurse responsible for delegation approves of an alternative method of preparation and administration of the medications.  On 2/2/16 at 2:00 PM the medication delegated staff member prepared Risperidone 0.125 milligrams for Resident #11. The resident was not alert and did not accept the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it into the medicine copy with the medication in it i |

|                          | of Licensing and Pro  | tection   |                              |  | 7 (3) (10)        | VELIONED.                |
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|                          | NT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPL<br>A. BUILDING: | E CONSTRUCTION   | (X3) DATE<br>COMP | SURVEY<br>LETED          |
|                          |   | 0377  | B. WING                      |  | 02/0              | C<br>03/2016             |
| NAME OF                  | PROVIDER OR SUPPLIER  | STREET AC   | DRESS, CITY, S               | TATE, ZIP CODE   |                   |                          |
| OUR HO                   | USE TOO RESIDENTI   | AL CARE HOME  | LEN STREET<br>D, VT 05701    | r  |                   |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SCIDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG          | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LDBE              | (X5)<br>COMPLETE<br>DATE |
| <sup>*</sup> R166        | Continued From pa   | ge 13   | R166                         |  |                   |                          |
|                          | medicine closet. At placed a call to the him/her know that it and asked if it could s/he received the ap s/he retrieved the R by the day shift care then crushed it and #11. At 3:20 PM s/r | tion and that it was in the 3:10 PM the staff member Registered Nurse to let had not been given at 2:00 I be given at this time. When oproval to give the medicine, isperidone that was prepared administered it to Resident the confirmed that s/he had in prepared by the other |                              |  |                   |                          |
| *R179<br>\$\$=E          | V. RESIDENT CAR   | E AND HOME SERVICES   | R1 <b>7</b> 9                |  |                   |                          |
|                          | demonstrate competechniques they are providing any direct shall be at least twel  | ust ensure that staff<br>tency in the skills and<br>expected to perform before<br>care to residents. There<br>ve (12) hours of training each<br>erson providing direct care to  | ,                            |  | 1                 |                          |
|                          |   | ing must include, but is not  |                              |  |                   |                          |
|                          | <ul> <li>(3) Resident emergiouch as the Heimlich or ambulance contact</li> <li>(4) Policies and proceedings of abuse, necessidents;</li> <li>(6) Infection control</li> </ul>               | cedures regarding mandatory glect and exploitation; effective interaction with measures, including but not  |                              |  |                   |                          |
|                          |   | ing, handling of linens,<br>vironments, blood borne   | -                            |  |                   |                          |

| Division of Licensing and Protection |   |   |  |  |                               |                          |
|--------------------------------------|---|---|--|--|-------------------------------|--------------------------|
|                                      | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION  A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED |                          |
|                                      | i   | 0377  | B. WING                                  |  | 02/03/                        | /2016                    |
| NAME OF I                            | PROVIDER OR SUPPLIER  |   | DRÆSS, CITY.                             | STATE, ZIP CODE  |                               |                          |
|                                      | USE TOO RESIDENTI   | AL CARE HOME 69 1/2 AL  | LEN STREE<br>), VT 05701                 |  |                               |                          |
| (X4) ID<br>PREFIX<br>TAG             | (EACH DEFICIENCY  | TEMENT ÓF DEFICIENCIES<br>' MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | IO<br>PREFIX<br>TAG                      | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)               | DBE                           | (X9)<br>COMPLETE<br>DATE |
| R179                                 | Continued From pa   | ge 14   | R179                                     |  |                               |                          |
|                                      |   | rersal precautions; and ision and care of residents.  | R179                                     | trainings are alwa   | ъ.<br>45                      | 3/17/16                  |
|                                      | by:<br>Based on employee<br>the facility failed to<br>receive twelve (12)   | NT is not met as evidenced a file review and staff interview ensure that 2 of 8 employees hours of training each year for   |  | mandatory - They use the more closely super for Compliance - Staff miss any mandatory me will be offered an alto | vised-<br>who<br>eeting       | ,                        |
|                                      | residents. The find   | roviding direct care to ings include the following:  e files on 2/3/16 presents that  |  | will be offered an after<br>training but must comp<br>such within 5 days or we<br>removed from the school        | native<br>ovete               |                          |
|                                      | two caregivers did r<br>hours of training. To<br>training hours in Em<br>Rights, Abuse/Negle<br>did not have training<br>This was confirmed | not have the required twelve<br>we caregivers did not have<br>hergency response, Resident<br>ect and Exploitation and one<br>g hours for Infection Control.<br>by the Human Resource<br>in 2/3/16 at 1:05 PM. |  | removed from the schodul<br>they comply.<br>the RN will mondar to<br>maintenance.                                | e until                       |                          |
| R187<br>SS=A                         | V. RESIDENT CAR   | E AND HOME SERVICES   | R187                                     |  |                               |                          |
| 33-A                                 | 5.12.b. (1)   |   | R187                                     | The original resident regular was destroyed during   | istor :                       | 2/16/16                  |
|                                      |   | including all discharges,<br>home and admissions.   |  | Construction - Since Sur<br>has been recreated and   | y which                       |                          |
|                                      |   | IT is not met as evidenced  |  | I have an allowed by the   | 2011 60                       | ·                        |
|                                      | facility failed to have   | view and record review, the<br>a a resident register that<br>ges, transfers out of the home<br>ndings include:  |  | manager, RR will be r<br>Once monthly at week!<br>managers meeting with<br>Administrator to month                | eviewed<br>to                 |                          |
|                                      | manager presented   | e resident register, the house<br>a current list of the census.<br>evious logs presented as   |  | for compliance and a   | cwacy.                        |                          |

| Division                 | of Licensing and Pro   | otection   |                          |   |   |                          |
|--------------------------|--|--|--------------------------|---|---|--------------------------|
| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:   |                          | LE CONSTRUCTION   | (X3) DATE S<br>COMPLI                                       |                          |
|                          |  | 0377   | 8. WING                  |   | C<br>02/03  | /2016                    |
| NAME OF                  | PROVIDER DR SUPPLIËR   | -  | DRESS, CITY,             | STATE, ZIP CODE   |   |                          |
| OUR HO                   | USE TOO RESIDEN <b>T</b>   | INT CARE HOME  | LEN STREE<br>D, VT 05701 |   |   |                          |
| (XA) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)   | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG      | PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPRIES DEFICIENCY)   | D BE  | (X5)<br>COMPLETE<br>DATE |
| R187                     | Continued From pa  | ge 15  | R187                     |   |   |                          |
|                          | on 2/2/16 at 11:35 /<br>include discharges   | mation by the house manager<br>AM that the register does not<br>of residents and that there are<br>t no longer resident at the   |                          |   |   |                          |
| R213<br>SS≍E             | VI. RESIDENTS' R   | IGHTS  | R213                     |   |   |                          |
|                          | consideration, resp resident's dignity, in home may not ask resident's rights.  This REQUIREMED by: Based on observatifacility failed to trea and dignity, Reside include:  1.) Resident # 9 w. Acetaminophen top the medication deletwo squirts from the gloved hands and a resident while the redining room table whad a visitor and the dining room. After member confirmed public area at the tiprobably should havelse. | rically on 2/2/16 at 12:15 PM, egated staff member applied by pump bottle into his/her applied it to the chest of the esident was seated at the vaiting for lunch. The resident ere were other residents in the the administration the staff that the resident was in a me of administration and it we been done somewhere | R213                     | Trainer has been advised poor execution from star with Survey Findings - so and the manager has met with these Caregor individually to review a train/retrain each appropriately have hours of informeducation on our individually have hours of informeducation on our individuals and family are aware and support to decisions - unconventional isn't uncommon- But all She done with dignity - 1.e. | she sections, or netonal many hours lies to be eating hours |                          |
|                          | wandering in the fa  | 45 PM, Resident #10 was cility with pajamas on and then<br>ng at the dining room table. At   |                          | PJ's Covered with a Robe or<br>Staff has been advised that  |   |                          |

₽9.JV11

| Division                 | of Licensing and Pro   | tection   |   |  |  |
|--------------------------|--|---|---|--|--|
| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | (X2) MULTIPLE CONSTRUCTION A. BUILDING: |  | (X3) DATE SURVEY<br>COMPLETED  |
|                          |  | 0377  | B. WING                                 |  | C<br>02/03/2016  |
| NAME OF I                | PROVIDER OR SUPPLIER   | STREET ADI  | ORESS, CITY, S                          | STATE, ZIP CDDE  |  |
| OUR HO                   | USE TOO RESIDENTI  | AL CARE HOME  | EN STREE<br>, VT 05701                  | т -  |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG                     | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY)   | D BE . COMPLETE  |
| R213                     | Continued From pa  | ge 16   | R213                                    | tesident who will only "pa-  | tonthe   |
| K.2.13                   | 5:05 PM Resident # dining room table in at this time present been incontinent an s/he is sometimes in not unusual to put the easier.  3.) On 2/2/16, during of for Resident # 7 began to cough and mouth. The caregiversident's shirt to so Resident #7's mout was completed, the confirmed at 4:10 P to wipe the mucous 4.) On 2/2/16, during observation at 5:45 eating a sandwich at fallen on the floor and her chair, s/he high drink and had during onto the plate and with the caregiver state him/her because the eat, but did confirm this meal was not did solved to protect residents are incontinuation. | 6 6 was also seen sitting at the a pajamas. Interview with staffed that the one resident had ad the other had a shower and resistive after dinner, so it was hem in pajamas because it is and a tube feeding observation at 4:00 PM, the resident had mucous in his/her wer used the hem of the coop the mucous out of h. When the tube feeding caregiver left the room. S/he will had she had used the shirt out of the mouth.  In the evening meal PM, Resident #10 had been and half of the sandwich had half of the sandwich had half of the other half was ad also spilled some of his/her pears was trying to bite the bowl. It did that they don't assist ey get angry and then won't that his/her appearance at | Contid                                  | Tesident who will only "par- go" Should be Served Small at one time monitoring che to Keep momentum going individual basis - Trainer and House ma will monitor per resident Need's are expected to the Curepian and Sta trained accordingly - Punchaser has been remin that cloth soakers show Not be white but more condinated with furnit coordinated with furnit white pads are intended white pads are intended white pads are intended resident bods - Trainer manager will monitor. Paragraph 3 was sloppy Caregiving at best - Caregiving at best - Caregiving at best and decision making. | amounts osely on an nager st- be-on ff  noted Id rolor rure- 1 for and 1/10/16 |
|                          |  | · .   |   | ,  | ·  |

| Division                 | of Licensing and Pro   | otection  |                     |  |  |                          |
|--------------------------|--|---|---------------------|--|--|--------------------------|
| STATEMEN                 | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '               | PLE CONSTRUCTION G:  | (X3) DATE<br>COMP  | SURVEY<br>LETED          |
|                          |  | 0377  | B. WING             |  | 02/0   | )<br>3/2016              |
| NAME OF                  | PROVIDER OR SUPPLIER   | STREET A()  | DRESS CITY          | , STATE, ZIP CODE  | <u></u>  |                          |
| OUR HO                   | USE TOO RESIDENT   | AL CARE HOME 69 1/2 AL  | LEN STRE            | ET   |  |                          |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | TEMENT OF DEFICIENCIES<br>'MUST 86 PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION SHOULD GROSS-REFERENCED TO THE APPRODEFICIENCY)  | .D BE  | (X5)<br>COMPLETE<br>DATE |
| R224                     | Continued From pa  | ge 17   | R224                | 1  |  |                          |
| R224<br>SS≕G             | ,  | _   | R224                |  |  | <br>                     |
|                          | verbal or physical a exploitation. Reside restraints as described. This REQUIREMENT by: Based on observation review, the facility for residents sampled, from sexual and physindings include the 1.) Per observation Resident # 6 had we Resident #2. Resid #6 and they were beinappropriately. The at the time of observed and the fact the time of observed that was in Resident #6 from the with the manager at dementia and the fact the behavior. At 10 caregiver that was in Resident #6 had was that s/he didn't think resident wandered to residents wander into said that the two will nothing has ever hall had been observed survey, directing his resident. Resident # | nts shall also be free from bed in Section 5.14.  IT is not met as evidenced on, staff interview and record alled to ensure that 2 of 8 Resident #3 and #6 were free visical abuse and neglect. The | R224                | All residents have demented staff is trained to month actions - families are par on going Communication Situations arise Acriate taken as deemed. Necessary - Each reside whereabouts is to be closely monitored a staff is trained to represent inappropriate find immediately - Acron placare established on a case by Case basis.  2) Not every acron Can be predicted thus the Value of our video surveillance system - the Careguer who was abandoned her Co worker did every right - once evidenced - Police were Called, APS + Exports were filed - Careguer is being prosecuted both | erits talltimer  or  for  guer  for  for  for  for  for  for  for  f | 2/17/16                  |
|                          | because both of their<br>resident of the oppor   | m were interested in another site sex. Per interview with   |                     | the VT STATE ATTORNEY GOT<br>another Caregiver was on  | site   |                          |

FORM APPROVED Division of Licensing and Protection

| DOUR HOUSE TOO RESIDENTIAL CARE HOME  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)  (X5) D PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETED.)  | STATEMEN | NT OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '   | LE CONSTRUCTION  | (X3) DATE SU<br>COMPLET   |                          |
|--|----------|--|---|---------|--|---|--------------------------|
| OUR HOUSE TOO RESIDENTIAL CARE HOME  SUMMARY STATEMENT OF DEFICIENCIES  REVULATION OF SIDENTIAL CARE HOME  SUMMARY STATEMENT OF DEFICIENCIES  REVULATION OF SIDENTIAL CARE HOME  REVULATION OF SIDENTIAL CARE SIDENTIAL CARE SIDENTIAL  REVULATION OF SIDENTIAL CARE HOME  REVULATION OF SIDENTIAL CARE  |          |  |   |         |  | 1   | <b>-</b>                 |
| OUR HOUSE TOO RESIDENTIAL CARE HOME  (SATHOUSE TOO RESIDENTIAL CARE HOME  (RACH DEFICIENCY MUST BE PRICEDED BY FULL TAG  RESOLUTIONY OR LSC IDENTIFYING INFORMATION)  RESOLUTIONY OR LSC IDENTIFYING INFORMATION  RESOLUTIONY OR LSC IDENTIFY INFORMATION)  RESOLUTIONY OR LSC IDENTIFY INFORMATION  RESOLUTIONY OR LSC IDENTIFY INFORMATION)  RESOLUTIONY OR LSC IDENTIFY INFORMATION  RESOLUTIONY OR LANGE OF THE ACTIONY OR LANGE OF THE ACTIONY OR LANGE O |          |  | 0377  | B. WING |  | 02/03/2   | 2016                     |
| ROTHOUSE TOO RESIDENTIAL CARE HOME  RUTLAND, VT 05701  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY ON LISC DENTIFTING INFORMATION)  RESOLATORY ON LISC DENTIFTING INFORMATION)  R224  Continued From page 18 that the residents not been monitored for behaviors of the type withessed, but they have hugged and held hands before and Resident #8 has been in the room of Resident #2 before, also confirmed that the helativor was inappropriate.  2.) Per review of intake information dated 11/5/16, provided by the facility administrator, Resident #3 was observed on a video surveillance lape dated 12/3/1/5 at 1:68:58 through 2:00:10, being pushed by resident to fall to the floor. The employee walked away from Resident #3 who was on duty at the time. Per intake information the perpetrator abandoned her/his position at approximately 9 AM, leaving the facility understaffed and without a medication technician.  Per observation of the video surveillance on 2/3/16 at approximately 9 AM, in the administration office for the four "Our House" facilities, with the administration stand the manager of the facility, confirmation is made that the surveillance tape evidences the physical abuse to Resident #3 by employee #1.  Per resident care service note dated 12/3/115, the resident redurned to the facility after Emergency Room evaluation with a diagnosis of right hip contusion and treatment advised.  R220 VI. RESIDENTS' RIGHTS  R221  Continue Recidence Action Should be accounted for the facility administrator.  R224  Continue Monitoring Resident daction technical Recident #2 facility and Cread-Reaction action per action of action per action of action per action of action per action per action per action of action per action per action per action per action of action per act | NAME OF  | PROVIDER OR SUPPLIER   |   | •       | ,  |   |                          |
| R224 Continued From page 18 that the residents not been monitored for behaviors of the type witnessed, but they have hugged and held hands before and Resident #6 has been in the room of Resident #2 before, also confirmed that the behavior was inappropriate.  2.) Per review of intake information dated 1/15/16, provided by the facility administrator, Resident #3 before and Resident to fall to the floor. The attendant #1, from behind causing the resident to fall to the floor. The attendant #2, who was on duty at the time. Per intake information at approximately 3 AM, leaving the facility understaifed and without a medication technician.  Per observation of the video surveillance on 2/3/16 at approximately 9 AM, in the administration office for the four "Our House" facilities, with the administrative staff and the amanager of the facility confirmation is made that the surveillance tape evidences the physical abuse to Resident #3 by employee #1.  Per resident care service note dated 12/3/1/5, the resident returned to the facility after Emergency Room evaluation with a diagnosis of right hip contursion and freatment advised.  R228 VI. RESIDENTS' RIGHTS  R228 R228 VI. RESIDENTS' RIGHTS  | OUR HO   | USE TOO RESIDENTI  | IAL CARE HOME   |         |  |   |                          |
| that the residents not been monitored for behaviors of the type witnessed, but they have hugged and held hands before and Resident #8 bas been in the room of Resident #2 before, also confirmed that the behavior was inappropriate.  2.) Per review of intake information dated 17/5/16, provided by the facility administrator, Resident #3 was observed on a video surveillance tape dated 12/3/1/5 at 1:58:58 through 2:00:10, being pushed by resident to fall to the floor. The entendant #1, from behind causing the resident to fall to the floor. The entendant did not offer the resident assistance nor did she report the occurrence to resident care attendant #2, who was on duty at the time. Per intake information the perpetrator abandoned her/his position at approximately 3 AM, leaving the facility understaffed and without a medication technician.  Per observation of the video surveillance on 2/3/16 at approximately 9 AM, in the administration office for the four "Our House" facilities, with the administrative staff and the manager of the facility, confirmation is made that the surveillance tape evidences the physical abuse to Resident earse ervice note dated 12/31/15, the resident care service note dated 12/31/15, the resident care revidences the physical abuse to Resident and the facility after Emergency Room evaluation with a diagnosis of right hip contusion and treatment advised.  R220 VI. RESIDENTS' RIGHTS  R228 VI. RESIDENTS' RIGHTS   | PREFIX   | (EACH DEFICIENCY   | Y MUST BE PRECEDED BY FULL  | PREFIX  | (EACH CORRECTIVE ACTION SHOUL<br>CRDSS-REFERENCED TO THE APPROPRIES  | OBE (   | (X6)<br>COMPLETE<br>DATE |
|  | R228     | that the residents no behaviors of the typ hugged and held hat has been in the roo confirmed that the k.  2.) Per review of in 1/15/16, provided by Resident #3 was obsurveillance tape dathrough 2:00:10, be attendant #1, from k fall to the floor. The Resident #3 who wastendant did not off did s/he report the cattendant #2, who wintake information to the facility understaitechnician.  Per observation of the 2/3/16 at approximal administration office facilities, with the admanager of the facilities, with the admanager of the facilities abuse to Resident #1.  Per resident care set the resident returned the re | ot been monitored for be witnessed, but they have ands before and Resident #6 am of Resident #2 before, also behavior was inappropriate.  Itake information dated by the facility administrator, been do not a video ated 12/31/15 at 1:58:58 and pushed by resident care behind causing the resident to be employee walked away from as lying on the floor. The fer the resident assistance nor occurrence to resident care was on duty at the time. Per the perpetrator abandoned approximately 3 AM, leaving and without a medication whe video surveillance on ately 9 AM, in the for the four "Our House" diministrative staff and the lity, confirmation is made that the evidences the physical by employee #1.  Betwice note dated 12/31/15, do to the facility after evaluation with a diagnosis of and treatment advised.  GHTS | Contó   | actions 24/7 and Creat action plans where necessarion plans where necessarion plans where necessarion responsibility of assurate plants are safe RN, manager, All state and administrator with monitor for Compliance Prior to admission all prosper families meet with the addrenation is discussed in despelle with dementia 1 ving a Community Can develop fine though untraditional, they create bonds - people with a normally need Comfort, Kn words, Soft touch, Care a compassion. This is expended affective in Creating a happy, healthy environ for our revidents and the | essary-  ff  ring  e,  ff  this  ministrator  fail-  gin  still  lementa  ind  ched  a  ment  erid  ched  a  ment  erid  erid |                          |
| 1 of to 1/69/delite upage the right to followers   |          |  |   | R228    | with the administrator   | <i>14/7.</i>  |                          |

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| Division of Licensing and Protection |   |   |                          |   |  |  |
|--------------------------------------|---|---|--------------------------|---|--|--|
| STATEME                              | NT OF DEFICIENCIES<br>I DF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1                        | LE CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED                    |  |
|                                      |   | 0377  | B. WING                  |   | C<br>02/03/2016                                  |  |
| NAME OF                              | PROVIDER OR SUPPLIER  | STREETAD  | DRESS, CITY,             | STATE, ZIP CODE   |  |  |
| OUR HO                               | USE TOO RESIDENTI   | IAL CARE HOME   | LEN STREE<br>D, VT 05701 |   |  |  |
| (X4) ID<br>PREFIX<br>TAG             | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG      | FROVIDER'S PLAN OF CORRECTS<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY)  | D BE   COMPLETE                                  |  |
| R228                                 | Continued From pa   | ge 19   | R228                     | ,   |  |  |
|                                      | advance directives as provided by state law and to have the home follow the residents' wishes   |   | R228                     | All residents have legal re<br>Some are family with   | many   |  |
| R247<br>\$S=E                        | by: Based on record re facility failed to assist sampled, formulate provided by state ta follow the residents the following:  Per record review of admitted to Our Horn Document titled "Te by the physician on follows: Do Not Rechanged by me. CI Sustaining Treatme Physician progress titled: "Impression" progress with family Intubate). {"I called we are in contact Conterview with the Ron 2/2/16 confirmate has not received and or the physician.  VII. NUTRITION AND T.2 Food Safety and T.2.b All perishable labeled, dated and I labeled and I | elephone Order Form" signed 6/15/15, identifies orders as esuscitate (DNR) unless inician Orders for Life ant (COLST) form in progress, note dated 8/31/15 paragraph (Imp.) #5 evidences COLST in for DNR/DNI (Do Not family in Pennsylvania and OLST mailed to him"). Per esidential Care Home Manger ion was made that the facility by COLST form from the family | R247                     | members - NOT all wind agree on advance directives, managers will maintain status changes and Conversation of Such in detail detail will be logge the resident chart - manager well manager well more manager well more | ectives encourage enent s ext - isod ges 2/26/14 |  |

| Division                 | Division of Licensing and Protection  |   |                                |   |   |  |
|--------------------------|---|---|--------------------------------|---|---|--|
| STATEMEN                 | IT OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  | 1 ' '                          | E CONSTRUCTION  | (X3) DATE SURVEY<br>COMPLETED           |  |
| e e                      |   | 0377  | ß. WING                        |   | C<br>02/03/2016                         |  |
| NAME OF I                | PROVIDER OR SUPPLIER  | STREET AD   | ADDRESS, CITY, STATE, ZIP CODE |   |   |  |
|                          | USE TOO RESIDENTI   | AL CARE HOME  | LEN STREE<br>), VT 05701       | r   |   |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG            | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)   | D BE COMPLETE                           |  |
| R247                     | Continued From pa   | ge 20   | R247                           |   |   |  |
|                          | heated prior to serv  | ice.  | RZ47                           | Staff has been reminded on the coper heed to labely date open   | Fithe 2/4/16                            |  |
|                          | This REQUIREMEN   | NT is not met as evidenced  | <br>                           | need to label/date Oper   | 7                                       |  |
|                          | Based on observatifacility failed to label Findings include:  1.) Accompanied by initial tour, it was observingerator #2 in the grape jelly, a jar of stuffed shells (per the of barbecue sauce cheese. None of the when they were open shredded cheese we contents were in the there was a package not have a label as | on and staff interview, the el and date all perishable food, by a caregiver on 2/2/16 for the eserved at 10:53 AM that exitchen, had two jars of applesauce, a container of the caregiver), lettuce, a bottle and a package of shredded lese items were dated as to ened. The shells and the rere not labeled as to what the expackages. In the freezer le of chicken nuggets that did to what the contents were and opened. These were |                                | Foods- Ananderbory in-service or will discuss in detail Surveyor Findings as Items in original cont with experation dates Not been practiced; The past-(4/14/15 px) au staff responsible for Comphance, manager | labeling 3/16/16 airrers has n oner fr) |  |
|                          | confirmed at the tim<br>caregiver.  | ne of discovery by the  |                                | will monitor  |   |  |
|                          | 2. In one of the kito<br>open jars of peanut<br>that were not dated<br>In a food storage be<br>open bag of cereal<br>without dates as to  | chen cupboards there were butter and a container of Fluff as to when they were open, ase cupboard there was an and and open macaroni, also when opened. These onfirmed by the caregiver at y.   |                                |   |   |  |
| R253<br>SS=D             | VII. NUTRITION AN   | ND FOOD SERVICES  | R253                           |   | İ                                       |  |
|                          | 7.3 Food Storage  | and Equipment   | ;<br>!                         |   | :                                       |  |
|                          | 7.3.c All food servi  | ce equipment shall be kept  |                                |   |   |  |

FORM APPROVED

| Division                                       | of Licensing and Pro                       | tection   |                     |  |                          |                           |
|--|--|---|---------------------|--|--------------------------|---------------------------|
| <b>-</b> · · · · · · · · · · · · · · · · · · · | IT OF DEFICIENCIES<br>OF CORRECTION        | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                         | ' '                 | E CONSTRUCTION   | (X3) DATE SUI<br>COMPLET |                           |
|  |  |   | , "-                |  | С                        |                           |
|  |  | 0377  | B. WING             |  | 02/03/2                  | 2016                      |
| NAME OF I                                      | PROVIDER OR SUPPLIER                       |   | IDRESS CITY         | STATE, ZIP CODE  | ·                        |                           |
| ,  |  | 69 1/2 AL   | LEN STREE           |  |                          |                           |
| OUR HO   | USE TOO RESIDENTI                          | IAL CARE HOME   | O, VT 05701         |  |                          | .,,,,                     |
| (X4) ID<br>PREFIX<br>TAG                       | (SACH DEFICIENCY                           | TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTI<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE C                  | (X\$)<br>COMPLETE<br>DATE |
| R253   | Continued From pa                          | ge 21   | R253                |  | . !                      |                           |
|  | clean and maintaine<br>manufacturer's guid |   | R253                | -this is just Careless-  | #·<br>:                  |                           |
|  | _  | NT is not met as evidenced  | 10000               | this is just Careless - staff has been remine  | ded 2                    | 14/16                     |
|  | by:  |   |                     | 10 LOW MARKERS Show  | י ום ו                   |                           |
|  |  | on and staff interview, the<br>ure that all food service                      |                     | be cleaned at the  | time                     |                           |
|  | equipment was kep                          | t clean. Findings include:  |                     | it occurs - also we  | N                        |                           |
|  |  | ir of the facility on 2/2/16 at   |                     | loe discussed at 3/16  |                          |                           |
|  |  | anied by caregiver, in the<br>ave turntable had dried peas                    |                     | سرحم بأراد سريعين الأرا  |                          |                           |
|  |  | re was build-up on the sides  |                     | marager will monitor   | or                       |                           |
|  | and top of the inside                      | e of the microwave. The   |                     | That begins  |                          |                           |
|  |  | this time that it should have<br>confirmed that there was food                |                     |  |                          |                           |
|  | build up in the micro                      |   |                     |  |                          | •                         |
| R259<br>SS=D                                   | VII, NUTRITION AN                          | ND FOOD SERVICES  | R259                |  |                          |                           |
|  | 7.3 Food Storage a                         | and Equipment   | R259                | Items have been secur<br>Locked boxes have   | 2d. 2                    | 14/16                     |
|  | 7.3 i Poisonous con                        | npounds (such as cleaning   |                     | been ordered For any   |                          |                           |
| ·  | products and insect                        | icides) shall be labeled for  |                     | loven oracres is an i  | nen =                    |                           |
|  |  | ind shall not be stored in the intess they are stored in a                    |                     | products in the Kild   | ابار                     |                           |
|  |  | mpartment within the food   | [<br>]              | Staff has been remin   | روی                      |                           |
|  | storage area.                              |   | E .                 | of regulations - also u  | eil                      |                           |
|  |  | NT is not met as evidenced  |                     | of regulations - also u<br>be discussed at 3/16  |                          |                           |
|  | by;<br>Based on observation                | on and staff interview, the   | }<br>!              | 10 5051100   |                          |                           |
|  | facility failed to store                   | e poisonous compounds in a  | ;                   | manager will mon   | intor                    |                           |
|  | locked compartment<br>Findings include:    | it in the food storage area.  | \$<br>{<br>:        |  |                          |                           |
|  | During the initial tou                     | ır on 2/2/16, accompanied by  |                     |  | į                        |                           |
|  | a caregiver, at 10:5                       | 3 AM, in the kitchen, there   |                     |  | İ                        |                           |

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| Division     | of Licensing and Pro   | tection   |                           |   | <del>,</del>               |
|--------------|------------------------|---|---------------------------|---|----------------------------|
| STATEMEN     | T OF DEFICIENCIES      | (X1) PROVIDER/SUPPLIER/CLIA                               | (X2) MULTIPLE             | E CONSTRUCTION  | (X3) DATE SURVEY COMPLETED |
| AND FLAN     | OF CORRECTION          | IDENTIFICATION NUMBER:                                    | A. BUILDING:              |   | COMPLETED                  |
|              |                        |   |                           |   | С                          |
|              | •                      | 0377  | B. WING                   |   | 02/03/2016                 |
|              |                        |   |                           |   |                            |
| NAME OF F    | PROVIOER OR SUPPLIER   |   |                           | ITATE, ZIP CODE   |                            |
| OUR HO       | USE TOO RESIDENTI      | AL CARE HOME  | LEN STREET<br>I, VT 05701 |   |                            |
| (X4) ID      |                        | TEMENT OF DEFICIENCIES                                    | ID                        | PROVIDER'S PLAN OF CORRECTION                                     |                            |
| PREFIX       |                        | / MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION) | PREFIX<br>TAG             | (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI   |                            |
| TAG          | KEGODATOKT OK D        | SC (SER (III.) INO INI GAMBATION                          | IAG                       | DEFICIENCY)   |                            |
|              |                        |   | 0050                      |   |                            |
| R259         | Continued From pa      | ge 22   | R259                      |   |                            |
|              | were eight cans of     | disinfectant spray, three cans                            |                           |   | ļ                          |
|              | of aerosol oven clea   | aner, two cans of aerosol                                 |                           |   | į į                        |
|              | furniture polish and   | 3 containers of Cascade                                   |                           |   |                            |
|              | dishwasher deterge     | ent. The manager of Our                                   |                           |   |                            |
|              | House Outback, wh      | no was at the facility to assist                          | ,                         |   |                            |
|              |                        | ofirmed that the chemicals                                |                           |   |                            |
|              |                        | y stored at the time of                                   |                           |   | ļ                          |
|              | discovery.             |   |                           |   |                            |
| 5000         |                        | ALT   | R266                      | •   |                            |
| R266<br>SS=D | IX. PHYSICAL PLA       | 'M'   | RZQQ                      |   |                            |
| აა−⊔         |                        |   |                           | 9 313 All 19 4 4  |                            |
|              | 9.1 Environment        |   | Releb 1                   | All families are aware of<br>the use of Socker pad                | 2/10/14                    |
| Ì            | 2.1 Ellandinion        |   | 1                         | the use of Socker pad   | s ' '                      |
| •            | 9.1.a The home m       | ust provide and maintain a                                |                           | on furniture, NOT only  |                            |
|              |                        | nitary, homelike and                                      | <b>!</b>                  | on turniture, No  | 150                        |
|              | comfortable enviror    | nment.  |                           | for incontinence but a  |                            |
|              |                        |   |                           | for spils - white sould were purchased to be a on resident beds - | LAFS                       |
|              |                        | NT is not met as evidenced                                | }                         | for species will  | cord                       |
|              | by:                    | in and staff intensious the                               |                           | were nurchased to be a  | ж <u>е</u>                 |
|              |                        | ion and staff interview, the idea and maintain a safe,    |                           | Last beds -   |                            |
|              |                        | homelike and comfortable                                  |                           | on resident   | 240                        |
|              | environment. Resid     | lent #7 regarding infection                               |                           | " Jesigner " Soaker pads  | are                        |
|              | control and homelik    | ce environment for all                                    |                           | "designer" soaker pads in the house and mor                       | · R 3/16/16                |
|              | residents. Findings    |   |                           | In the house and every  | ' '                        |
| ·            |                        |   |                           | have been ordered -   | . d                        |
|              | 1.) Per observation    | on on 2/2/16 and 2/3/16, the                              |                           | at of hat been remined  | . 4                        |
|              | facility uses large of | loth incontinent pads on the                              |                           | 1 115P - POVIEW   | )                          |
|              | couches and chairs     | s. Per house manager, they the furniture when the         |                           |   |                            |
|              | residents are incon    | tinent. On 2/3/16 at 5:45 PM                              |                           | to be done at in-seri   | 10 -                       |
|              |                        | t it did not a homelike                                   |                           | 3/14. All staff responsible manager to monitor                    | ) ME -                     |
|              | environment for the    |   | <br>                      | branager to mondor  | •                          |
|              |                        |   | :                         | 17 lack languages   | 1. [1]                     |
|              | 2.) During initial to  | our of facility, accompanied by                           | -1                        | Damsible stattwas gu  | estioned i                 |
|              | caregiver on 2/2/16    | at 10:50 AM, Resident #7 had                              | 2                         | and -all  |                            |
|              |                        | at the bedside. Resident #7                               |                           | and reprimanded - ail   |                            |
|              | requires oral suctio   | ning as needed, there was                                 | 1                         | Staff Knows proper use  | -ge                        |

| Division of              | of Licensing and Pro               | tection   |                     |  |                               |
|--------------------------|------------------------------------|---|---------------------|--|-------------------------------|
|                          | T OF DEFICIENCIES<br>OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:                         | ' '                 | E CONSTRUCTION   | (X3) DATE SURVEY<br>COMPLETED |
|                          |                                    |   |                     |  | С                             |
| ı                        |                                    | 0377  | B, WING             |  | 02/03/2016                    |
| NAME OF F                | ROVIDER OR SUPPLIER                | STREET ADI  | DRESS, CITY,        | STATE, ZIP CODE  |                               |
|                          | JSE TOO RESIDENT                   | AL CARE HOME 69 1/2 ALI   | EN STREE            | т  |                               |
| OUK HOU                  | JSE TOO RESIDENTS                  | AL CARE HOME RUTLAND  | , VT 05701          | ······································   |                               |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)                   | JEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROVIDERICENCY) | DBE ; COMPLETE                |
| R266                     | Continued From pa                  | ge 23   | R266                | Including Cleaning -   |                               |
| ` .                      | thick yellow mucou                 | s in the tubing as well as the  |                     | review and retraini.   | 19                            |
|                          | Yankaur Suction or                 | al apparatus. Per the   |                     | completed by mana  | ger-                          |
|                          | caregiver, the resid               | ent probably needed to be e night and the tubing is                           |                     |  | V                             |
|                          | suppose to be clea                 | nsed with water after each  |                     |  |                               |
|                          |                                    | firmed at this time that the  |                     |  |                               |
|                          | tubing and oral pied               | ce had not been cleansed.   |                     |  |                               |
| R272<br>SS=D             | IX. PHYSICAL PLA                   | NT  | R <b>2</b> 72       |  |                               |
|                          |                                    |   | R272                | NISO Submitted after Survey  | ·                             |
|                          | 9.2 Residents' Roo                 | oms   | 10                  | Also Submitted after Survey<br>was a letter dated 3/31/  | 03                            |
|                          | no - Bouldertha                    | tree and shall be used only as  |                     | I see the selected that  | ' I                           |
|                          |                                    | irooms shall be used only as<br>ng and living quarters of the                 |                     | IN WHICH IT STONE  | i American                    |
|                          | residents assigned                 |   |                     | " two physical plant varia   | 3/45.3                        |
| ļ                        | -                                  |   |                     | were given at the time   |                               |
|                          | by:                                | NT is not met as evidenced  |                     | "two physical plant various of original license  |                               |
|                          |                                    | ion and staff interview, the  |                     | one of the two has been  |                               |
|                          |                                    | re that resident's bedrooms epersonal sleeping and living                     |                     | rectified years ago - +1   | 15                            |
|                          | quarters of the resi               | dents assigned to them for 1  |                     | one remains - There ha   | ve.                           |
|                          | of 13 residents, Re                | sident # 5. Findings include:   | !                   | Glways been two very   |                               |
|                          | During a tour of the               | e facility on 2/2/16 at 10:30 AM  |                     | always been the  | End                           |
|                          | accompanied by a                   | caregiver, it was observed that   | į                   | large closets in the room  |                               |
| İ                        | Resident #5 had tw                 | o closets in their room. Upon   | <u> </u>            | every occupants famil  | <i>y</i>                      |
|                          | inspection, one of t               | the closets contained a   |                     | has been made aware a  | F                             |
|                          |                                    | torage boxes for things<br>irmacy, some linen and                             |                     | it's use - Thems in this   |                               |
|                          | blankets and other                 | items. The caregiver stated   |                     | Closet need only be access   | sed                           |
|                          | that the closet was                | used for storage for the  | [<br>r              | when the resident would  | d                             |
|                          | facility. \$/he confir             | med at this time that staff have  | -                   | menting festives.  |                               |
|                          | to go in and out of                | Resident #5's bedroom in<br>from the closet and that the                      |                     | normally be out of the   | est                           |
|                          | resident can't store               | any of their belongings in that   | j                   | room. I would ask the  |                               |
|                          | closet.                            | ,   | :                   | this be understood as  | m ded                         |
|                          |                                    |   | ;                   | ongoing as space is 1  | (r/() (-) .                   |

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Division of Licensing and Protection (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ Ċ. B. WING 02/03/2016 0377 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 69 1/2 ALLEN STREET OUR HOUSE TOO RESIDENTIAL CARE HOME RUTLAND, VT 05701 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) Accessing the closet from outside R302 R302 Continued From page 24 of the room has been explored R302 R302 IX. PHYSICAL PLANT SS≍B but a heating pipe is an obstacle as well as it being 9.11 Disaster and Emergency Preparedness accessed in the outside 9.11.c Each home shall have in effect, and hallway. available to staff and residents, written copies of a plan for the protection of all persons in the event of fire and for the evacuation of the building when necessary. All staff shall be instructed Staff has a schedule periodically and kept informed of their duties R302 every year for fire dalls-this is an unacceptable under the plan. Fire drills shall be conducted on at least a quarterly basis and shall rotate times of day among morning, afternoon, evening, and 2/4/16 night. The date and time of each drill and the oversight - Firedall names of participating staff members shall be schedules will be reviewed documented. monthly at a weekly managers meeting and have been added to the This REQUIREMENT is not met as evidenced by: Based on staff interview and record review, the managers daily handbookfacility failed to conduct fire drills on a quarterly basis. Findings include: six fine drills are Scheduled and must During review of facility conducted fire drills on 2/2/16, the last conducted fire drill was 6/24/15. be conducted for Interview with the house manager at 11:35 AM, Compliance with DLP and Fire Safety Codes -manager will monitor. s/he stated that s/he thought they had to do six per year and after reviewing the State Regulations for Residential Care Homes, s/he confirmed that s/he had not completed the fire drills quarterly. R999 R999 MISCELLANEOUS SS=C Based on observation and staff interview, the facility failed to encourage or provide activities for the Enhanced Residential care residents.

| Division          | of Licensing and Pro                       | otection   | T                           | C COUNTRILOTION   | (X3) DATE SURVEY                       |
|-------------------|--|--|-----------------------------|---|--|
| STATEMEN          | T OF DEFICIENCIES                          | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:               | (X2) MUI,TIPLE CONSTRUCTION |   | COMPLETED                              |
| ∧ND PLAN          | OF CORRECTION                              | IDENTIFICATION NOWDER.   | A BUILDING:                 |   |  |
|                   |  |  |                             |   | C                                      |
|                   |  | 0377   | B. WING                     |   | 02/03/2016                             |
|                   | A OVER OR SURBUER                          | STREET AD  | DRESS CITY. S               | STATE, ŻIP CODE   | Ì                                      |
| NAME OF F         | PROVIDER OR SUPPLIER                       |  | LEN STREE                   |   |  |
| OUR HO            | USE TOO RESIDENT                           | 1 4 ) / / 4 0 5 11 (10 10 10 10 10 10 10 10 10 10 10 10 10 1     | D, VT 05701                 |   |  |
|                   | CHAMAADY ST/                               | ATEMENT OF DEFICIENCIES  | in in                       | PROVIDER'S PLAN OF CORRECTION                               | ON (X5)                                |
| (X4) ID<br>PREFIX | (EACH DEFICIENC)                           | Y MUST BE PRECEDED BY FULL                                       | PREFIX                      | (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO | D BE COMPLETE PRIATE DATE              |
| TAG               | REGULATORY OR L                            | SC IDENTIFYING INFORMATION)                                      | TAG                         | DEFICIENCY)   |  |
|                   |  |  |                             |   |  |
| R999              | Continued From pa                          | age 25   | R999                        |   |  |
|                   | Findings include:                          | ·  |                             |   |  |
|                   |  |  | 0000                        | in it is an axoute  | ed                                     |
|                   | It was observed on                         | 2/2/16 that most of the  | R999                        | Activities are expects                                      |  |
|                   | residents were sea                         | eted in chairs in the sitting area as turned on to music videos. |                             | each day on at leas   | 51 3/16/16                             |
|                   |  | as turned on to music videos.  I at the tables in the dining     | į                           |   | 3/1-1.1                                |
| ļ                 | room and a couple                          | were walking about the facility                                  |                             | two shifts -  |  |
|                   | At 2:00 PM, a staff                        | member was asked about the                                       |                             | Trainer has reviewed  | 1                                      |
|                   | type of activities th                      | e residents do, s/he said that                                   |                             | Trainer has reviewed  | -                                      |
|                   | they had not been                          | done today and there aren't                                      |                             | the definition and  |  |
| •                 | very many activitie                        | s for the residents. Another                                     | 1                           | expectations with   | 2/4/16                                 |
|                   | staff member resp                          | onded that there are no  |                             | expectations  | ~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~ |
|                   | activities for the re                      | sidents. S/he said that they do                                  |                             | Staff interviewed -   | -                                      |
|                   | them if they have t                        | ime, but not every day, usually<br>Staff member that is          |                             |   |  |
| •                 | responsible for edi                        | ucation regarding care stated                                    |                             | and well be discussed                                       | <u>*</u> (3)                           |
|                   | that they have a so                        | cheduled activity book, but s/he                                 | Ì                           | at 3/16 in-service  | <u>*</u> •                             |
|                   | can not locate it. S                       | S/he said that they try to do                                    |                             | 1 61 3/10 M. 80.  |  |
|                   | something every d                          | ay, but sometimes it gets too                                    | ļ                           | Towner and mana   | ger                                    |
|                   | busy. The evenin                           | g medication staff stated that                                   | 1                           | Trainer and mana will monitor for                           | <i>J</i>                               |
|                   | there are no activit                       | ties because they are too busy.                                  | ٠ [                         | will months to  |  |
|                   | but the residents in<br>let them color whe | ke to color and they will try to                                 | ļ                           | Compliance -  |  |
|                   | INTERPRETATION AND                         | never usey can.  |                             | Compilario  |  |
|                   |  |  |                             |   |  |
|                   | Resource: Vermo                            | nt Department of Disabilities,                                   |                             |   |  |
| •                 | Aging and Indeper                          | ndent Living   |                             |   | · '   · '                              |
|                   | Choices for Care,                          | Lon-Term Care Medicaid   | 1                           | · ·   |  |
|                   |  | Page IV.82, #4 Recreational                                      |                             |   |  |
|                   | Activities.                                |  |                             |   | <b>\</b>                               |
|                   |  |  |                             |   |  |
|                   | ļ  |  | !                           |   |  |
|                   |  |  | }                           |   |  |
|                   |  |  | (                           |   |  |
|                   |  |  | !                           |   |  |
|                   |  |  | •                           |   |  |
| ,                 |  |  |                             |   |  |
|                   |  |  |                             |   |  |